2010 WL 5267297 (Ark.Cir.) (Trial Pleading)
Circuit Court of Arkansas.
5th Division
Pulaski County

Mary E. HUGHES, as Executrix of the Estate of Mildred Smith, Deceased,
and on Behalf of the Wrongful Death Beneficiaries of Mildred Smith, Plaintiff,
v.
HEALTH FACILITIES MANAGEMENT CORPORATION and Little Rock Healthcare
#1, Inc. d/b/a Little Rock Healthcare & Rehabilitation Center, Defendants.

No. CV021871.
February 22, 2010.

Complaint

Mary E. Hughes, as Executrix of the Estate of Mildred Smith, Deceased, and on Behalf of the Wrongful Death Beneficiaries of Mildred Smith Brian D. Reddick #94057, Susan N. Childers #95221, Wilkes & McHugh, P.A., 425 West Capitol Avenue, Suite 3500, Little Rock, Arkansas 72201, Telephone: (501) 371-9903, Facsimile: (501) 371-9905.

Plaintiff, Mary E. Hughes, as Executrix of the Estate of Mildred Smith, Deceased, and on Behalf of the Wrongful Death Beneficiaries of Mildred Smith, states:

1. Mary E. Hughes is the Executrix of the Estate of Mildred Smith, deceased, pursuant to Pulaski County Circuit Court Order No. PDE-2001-1421 and brings this action on behalf of the Estate of Mildred Smith and the wrongful death beneficiaries of Mildred Smith, pursuant to the Arkansas Survival of Actions Statute (Ark. Code Ann. § 16-62-101) and the Arkansas Wrongful Death Act (Ark. Code Ann. § 16-62-102).

2. Mary E. Hughes is the niece of Mildred Smith.

3. Mildred Smith was a resident of Little Rock Healthcare #1, Inc. d/b/a Little Rock Healthcare & Rehabilitation Center (Little Rock Healthcare) located at 5720 West Markham Street, Little Rock, Pulaski County, Arkansas 72205, from on or about January 27, 1997 through March 21, 2000.

4. Defendant Little Rock Healthcare is an Arkansas corporation engaged in the for-profit custodial care of **elderly** individuals who are chronically infirm, mentally impaired, and/or in need of nursing care and treatment. The agent for service of process for Little Rock Healthcare is Trudy Hall, 840 Batesville Boulevard, Batesville, Arkansas 72501.

5. Defendant Health Facilities Management Corporation (Health Facilities) is a foreign for-profit corporation that operated, controlled and managed Little Rock Healthcare at all relevant times mentioned herein pursuant to a management agreement assuming the liability described and complained of herein. See Exhibit A. The agent for service of process for Health Facilities is Trudy Hall, 840 Batesville Boulevard, Batesville, Arkansas 72501.

6. Jurisdiction and venue are proper in this Court.

FACTUAL ALLEGATIONS AGAINST DEFENDANTS

7. On January 27, 1997, Mildred Smith was admitted to Little Rock Healthcare where she remained a resident until March 21, 2000.

8. Defendants were aware of Mildred Smith's medical condition and the care she required when they represented that they could adequately care for her needs.

9. In an effort to ensure that Mildred Smith and other residents whose care was partially funded by the government were placed at Little Rock Healthcare, Defendants held themselves out to the Arkansas Department of Human Services (DHS) and the public at large as being:
a) Skilled in the performance of nursing, rehabilitative and other medical support services;

b) Properly staffed, supervised, and equipped to meet the total needs of its nursing home residents;

c) Able to specifically meet the total nursing home, medical, and physical therapy needs of Mildred Smith and other residents like her; and

d) Licensed by DHS and complying on a continual basis with all rules, regulations, and standards established for nursing homes.

10. Defendants failed to discharge their obligations of care to Mildred Smith with a conscious disregard for her rights and safety. At all times mentioned herein, Defendants, through their corporate officers and administrators, had knowledge of, ratified and/or otherwise authorized all of the acts and omissions that caused the injuries suffered by Mildred Smith, as more fully set forth below. Defendants knew that the nursing staff could not provide even the minimum standard of care to the weak and vulnerable residents of Little Rock Healthcare. The severity of the recurrent negligence inflicted upon Mildred Smith while under the care of the facility accelerated the deterioration of her health and physical condition and resulted in the physical and emotional trauma described below:
a) Bedsores, otherwise known as decubitus ulcers or pressure sores, which developed on Mildred Smith's right and left ankles, bilateral greater trochanters and sacrum, causing her to undergo otherwise unnecessary medical treatments as well as causing excrutiating pain, suffering and mental anguish;

b) Numerous festering, pus-infiltrated and necrotic pressure sores on the body of Mildred Smith that ultimately became infected, including a Stage IV bedsore on her left ankle that became infected with methicillin-resistant S. *aureus* (MRSA) and draining, necrotic Stage III/IV areas on Mildred Smith's bilateral greater trochanters;

c) Malnutrition;

d) Anemia;

e) Dehydration;

f) An infected PEG tube as documented by St. Vincent Infirmary on March 21, 2000;

g) A fractured right distal tibia on August 3, 1999 after the facility's van driver failed to secure Mildred Smith's wheelchair;

h) Contractures of all four of Mildred Smith's extremities, which left her frozen in the fetal position as documented at St. Vincent Infirmary on March 21, 2000;

i) A urinary tract infection that led to urosepsis and renal insufficiency as diagnosed by St. Vincent Infirmary on March 21, 2000; and

j) Death.

All of the above-identified injuries, as well as the conduct specified below, caused Mildred Smith to lose her personal dignity and caused her death to be preceded by extreme and unnecessary pain, degradation, anguish, otherwise unnecessary hospitalizations and emotional trauma.

11. Defendants controlled the operation, planning, management, and quality control of Little Rock Healthcare. The authority exercised over the nursing facility included, but was not limited to, budgeting, marketing, human resources management, training, staffing, creation and implementation of all policy and procedure manuals used by the nursing facilities in Arkansas, federal and state reimbursement, quality care assessment and compliance, licensure and certification, legal services, and financial, tax and accounting control through fiscal policies established by Defendants.

12. Upon information and belief, Defendants operated and managed the facility so as to maximize profits by reducing staffing levels below that needed to provide adequate care to residents that would comply with federal and state regulations governing skilled nursing facilities. Specifically, Defendants intentionally and/or with reckless disregard for the consequences of their actions caused staffing levels at Little Rock Healthcare to be set so that the personnel on duty at any given time could not reasonably tend to the needs of their assigned residents. Upon information and belief, Defendants knowingly established staffing levels that created recklessly high nurse/resident ratios and disregarded patient acuity levels as well as the minimal time required to perform essential functions. All of these acts of malfeasance directly caused injury to Mildred Smith and other residents of Little Rock Healthcare and were known to Defendants, their corporate officers and administrators.

13. Upon information and belief, the acts and omissions of Defendants were motivated by a desire to increase the profitability of Little Rock Healthcare by reducing expenditures for needed staff, training, supervision, and care to levels that would predictably lead to severe injury.

14. Plaintiff alleges that oh all occasions complained of herein, Mildred Smith was under the care, supervision, and treatment of Defendants and that the injuries complained of were proximately caused by the acts and omissions of Defendants.

15. Defendants and their administrators had vicarious liability for the acts and omissions of all persons or entities under their control, either directly or indirectly, including employees, agents, consultants, and independent contractors, whether in-house or outside entities, individuals, agencies, or pools causing or contributing to the injuries of Mildred Smith.

COUNT ONE NEGLIGENCE AS DEFINED BY THE ARKANSAS MEDICAL MALPRACTICE ACT

16. Plaintiff incorporates all allegations contained in Paragraphs 1-15.

17. Defendants owed a non-delegable duty to residents, including Mildred Smith, to use reasonable care in treating their residents with the degree of skill and learning ordinarily possessed and used by nursing home facilities in the same or similar locality.

18. Defendants owed a non-delegable duty to assist all residents, including Mildred Smith, in attaining and maintaining the highest level of physical, mental and psychosocial well-being.

19. Defendants failed to meet the applicable standards of care and violated their duty of care to Mildred Smith through mistreatment, abuse and **neglect**. Defendants failed to adequately supervise nurses and aides and failed to hire sufficient nurses and aides. As such, the nurses and aides were unable to provide Mildred Smith the requisite care, and as a result negligent acts occurred as set forth in this paragraph. The medical negligence of Defendants includes, but is not limited to, the following acts and omissions:

a) The failure to ensure that Mildred Smith received the following:

1. Timely and accurate care assessments;

2. Proper treatment, medication and diet;

3. Necessary supervision; and

4. Timely nursing and medical intervention due to a significant change in condition;

b) The failure to establish, publish, and/or adhere to policies for nursing personnel concerning the care and treatment of residents with nursing, medical, and psychosocial needs similar to those of Mildred Smith;

c) The failure to provide, implement, and ensure adequate nursing care plan revisions and modifications as the needs of Mildred Smith changed;

d) The failure to provide, implement and ensure that an adequate nursing care plan for Mildred Smith was followed by nursing personnel;

e) The failure to provide care, treatment, and medication in accordance with physician's orders;

f) The failure to ensure that Mildred Smith received adequate and proper nutrition, fluids, therapeutic diet and sanitary care treatments to prevent her from lying in her own urine and feces for extended periods of time;

g) The failure to provide accurate and complete weekly skin audits on Mildred Smith to accurately detect and prevent skin breakdown;

h) The failure to properly assess Mildred Smith for the risk of development of ulcers, lesions and bedsores on her body;

i) The failure to provide Mildred Smith with adequate and appropriate observation and examination for skin breakdown so as to timely and adequately intervene to prevent the formation and worsening of ulcerated, pus-infiltrated, festering, and necrotic sores and lesions on her body that ultimately became infected;

j) The failure to provide Mildred Smith with adequate and appropriate nursing care, treatments and medication after the development of bedsores over her body so as to prevent the aggravation and deterioration of these bedsores;

k) The failure to provide proper treatment and assessment to Mildred Smith in order to prevent the development and worsening of numerous bedsores, some of which progressed to Stage IV and became infected, malnutrition, anemia, dehydration, an infected PEG tube, a fractured right distal tibia, contractures, a urinary tract infection, urosepsis and renal insufficiency;

I) The failure to provide adequate and appropriate toileting care to Mildred Smith in order to prevent a urinary tract infection that led to urosepsis and renal insufficiency is diagnosed at St. Vincent Infirmary on March 21, 2000;

m) The failure to provide and maintain an adequate and appropriate fluid maintenance program for Mildred Smith to prevent dehydration;

n) The failure to ensure that Mildred Smith received adequate assessment and treatment to ensure her nutritional needs were met;

o) The failure to provide Mildred Smith with adequate and appropriate nutrition to prevent malnutrition;

By way of example only, Ms. Smith's attending physician at St. Vincent Infirmary noted in his discharge summary on March 27, 2000 that Ms. Smith had a malfunctioning PEG tube when she entered the hospital from the nursing home on March 21, 2000;

p) The failure to provide adequate and appropriate care to Mildred Smith's PEG tube, resulting in an infected PEG tube as documented at the St. Vincent Infirmary emergency room on March 21, 2000;

q) The failure to adequately and appropriately monitor Mildred Smith and recognize significant changes in her health status;

r) The failure to provide Mildred Smith with adequate and appropriate range of motion exercises which resulted in Mildred Smith becoming frozen in the fetal position as documented at St. Vincent Infirmary on March 21, 2000; and

s) The failure to properly and timely notify the attending physician of Mildred Smith of significant changes in her physical condition, to wit: the development and worsening of numerous bedsores, some of which progressed to Stage IV and became infected, malnutrition, anemia, dehydration, an infected PEG tube, a fractured right distal tibia, contractures, a urinary tract infection, urosepsis, renal insufficiency and persistent, unresolved problems relating to the care and physical condition of Mildred Smith causing her needless and unnecessary pain, agony, and suffering.

20. A reasonably prudent nursing home, operating under the same or similar conditions, would not have failed to provide the care listed in the above complaint. Each of the foregoing acts of negligence on the part of Defendants was a proximate cause of Mildred Smith's injuries, which were all foreseeable to Defendants.

21. Defendants were negligent and reckless in breaching the duties owed to Mildred Smith under the Medical Malpractice Act for the reasons specifically enumerated in this Complaint.

22. As a direct and proximate result of such grossly negligent, willful, wanton, reckless, malicious, and/or intentional conduct, Mildred Smith suffered injuries as described in Paragraph 10. Plaintiff asserts a claim for judgment for all compensatory and punitive damages against Defendants, including, but not limited to, medical expenses, physical pain and suffering, mental anguish, disability, loss of enjoyment of life, humiliation, emotional distress and death in an amount to be determined by the jury and exceeding that required for federal court jurisdiction in diversity of citizenship cases, plus costs and all other relief to which Plaintiff is entitled by law.

COUNT TWO NEGLIGENCE

23. Plaintiff incorporates all allegations set forth in Paragraphs 1 - 22.

24. Defendants owed a non-delegable duty to residents, including Mildred Smith, to provide adequate and appropriate custodial care and supervision that a reasonably careful person would provide under similar circumstances.

25. Defendants owed a non-delegable duty to residents, including Mildred Smith, to exercise reasonable care in providing care and services in a safe and beneficial manner.

26. Defendants owed a non-delegable duty to residents, including Mildred Smith, to hire, train and supervise employees to deliver care and services to residents in a safe and beneficial manner.

27. Defendants breached these duties by failing to exercise reasonable care and by failing to prevent the mistreatment, abuse and **neglect** of Mildred Smith. The negligence of Defendants includes, but is not limited to, the following acts and omissions:

a) The failure to ensure that Mildred Smith attained and maintained her highest level of physical, mental and psychosocial well-being;

b) The failure to feed Mildred Smith to prevent malnutrition;

c) The failure to provide and ensure that Mildred Smith received adequate hygiene and sanitary care to prevent infections;

d) The failure to provide adequate turning and repositioning of Mildred Smith in order to provide pressure relief so as to prevent the formation and worsening of numerous bedsores on her body;

e) The failure to ensure that Mildred Smith received sufficient amounts of fluids to prevent dehydration;

f) The failure to provide Mildred Smith with adequate and appropriate hygiene care, including the failure to bathe her daily and after each incontinent episode to prevent urine and fecal contact with her skin for extended and medically unsafe periods of time;

g) The failure to provide a safe environment;

By way of example only, on August 3, 1999, the facility's van driver failed to secure Mildred Smith's wheelchair. As a result, she suffered a fractured right distal tibia and a large hemotoma to the face;

h) The failure to comply with the Arkansas minimum staffing law, *LTC 89-M-24*, in providing the minimum number of staff necessary to assist the residents with their needs;

i) The failure to provide sufficient numbers of qualified personnel, including nurses, licensed practical nurses, certified nurse assistants, and medication aides (nursing personnel) to meet the total needs of Mildred Smith throughout her residency;

j) The failure to provide a nursing staff that was properly qualified and trained;

k) The failure to increase the number of nursing personnel at Little Rock Healthcare to ensure that Mildred Smith:

1. Received timely and accurate care assessments;

2. Received prescribed treatment, medication, and diet;

3. Received necessary supervision; and

4. Received timely nursing and medical intervention due to a significant change in condition;

I) The failure to adequately assess, evaluate, and supervise nursing personnel so as to ensure that Mildred Smith received appropriate nursing care in accordance with Defendants' policies and procedures and the Rules of the Arkansas Department of Health Services and Office of Long Term Care;

m) The failure to adequately screen, evaluate, and check references, test for competence, and use ordinary care in selecting nursing personnel to work at Little Rock Healthcare;

n) The failure to terminate employees at Little Rock Healthcare assigned to Mildred Smith that were known to be careless, incompetent, and unwilling to comply with the policy and procedures of Little Rock Healthcare and the rules and regulations promulgated by the Arkansas Department of Health and Services and the Office of Long Term Care;

o) The failure to assign nursing personnel at Little Rock Healthcare duties consistent with their education and experience based on:

1. Mildred Smith's medical history and condition, nursing, and rehabilitative needs;

2. The characteristics of the resident population residing in the area of the facility where Mildred Smith's was a resident; and

3. The nursing skills needed to provide care to such resident population;

p) The failure to adopt adequate guidelines, policies, and procedures for:

1. Investigating the relevant facts, underlying deficiencies, or licensure violations or penalties found to exist at Little Rock Healthcare by the Arkansas Office of Long Term Care or any state or federal survey agency;

2. Determining the cause of any such deficiencies, violations, or penalties;

3. The method and means for correcting deficiencies or licensure violations or penalties found to exist at Little Rock Healthcare;

q) The failure to adopt adequate guidelines, policies, and procedures for documenting, maintaining files, investigating, and responding to any complaint regarding the quantity of patient care, the quality of patient care, or misconduct by employees at Little Rock Healthcare irrespective of whether such complaint derived from a state or federal survey agency, a resident or employee of the facility, or any interested person;

r) The failure to take reasonable steps to prevent, eliminate and correct deficiencies and problems in resident care at Little Rock Healthcare;

s) The failure by the members of the governing body to discharge their legal and lawful obligation by:

1. Ensuring that the rules and regulations designed to protect the health and safety of the residents, such as Mildred Smith, as promulgated by the Arkansas Department of Health and Services and the Arkansas Office of Long Term Care were consistently complied with on an ongoing basis;

2. Ensuring that the resident care policies for Little Rock Healthcare were consistently complied with an ongoing basis; and

3. Ensuring that appropriate corrective measures were implemented to correct problems concerning inadequate resident care;

t) The failure to provide care, treatment, and medication in accordance with physician's orders;

u) The failure to maintain medical records on Mildred Smith in accordance with accepted professional standards and practices that are complete, accurately documented, readily accessible, and systematically organized with respect to her diagnosis, treatment and the assessment and establishment of appropriate care plans of care and treatment; and

v) The failure to properly notify the family of Mildred Smith of significant changes in her health status.

28. A reasonably careful nursing home operating under similar circumstances would foresee that the failure to provide the ordinary care listed above would result in devastating injuries to Mildred Smith.

29. Defendants further breached their duty of care to Mildred Smith by violating certain laws and regulations in force in the State of Arkansas at the time of the occurrences discussed herein including, but not limited to the following:
a) By failing to comply with rules and regulations promulgated by the Arkansas Department of Human Services, Division of Social Services, Office of Long Term Care, pursuant to authority expressly conferred by. Act 28 of 1979 (Ark. Code Ann. § 20-10-202, *et seq.)* and published in the Long Term Care (LTC) Provider Manual on April 8, 1984, and the supplements thereto, and the federal minimum standards imposed by the United States Department of Health and Human Services (42 C.F.R. § 405.301, *et seq.);*

b) By violating the aforementioned regulations cited in subparagraph a) and including, but not limited to:

1. By failing to provide Mildred Smith with sufficient fluid intake to maintain proper hydration and health 42 C.F.R. § 483.25(j);

2. By failing to provide the necessary care and services to attain or maintain the highest practicable physical, mental and psychosocial well-being of Mildred Smith, in accordance with the comprehensive and assessment - plan of care created at Little Rock Healthcare. 42 C.F.R. § 483.25;

3. By failing to treat Mildred Smith courteously, fairly, and with the fullest measure of dignity. 42 C.F.R § 483.15(a);

4. By failing to provide appropriate toileting care to prevent urinary tract infections. 42 C.F.R § 483.25(d);

5. By failing to provide sufficient nursing staff and nursing personnel to ensure that Mildred Smith attained and maintained her highest practicable physical, mental and psychosocial well-being. 42 C.F.R. §483.30;

6. By failing to provide the minimum number of staff and nursing personnel as required by the Arkansas minimum staffing requirement, *LTC-89-M-24;*

7. By failing to ensure a nursing care plan based on Mildred Smith's problems and needs was established that contained measurable objectives and timetables to meet her medical, nursing, and mental and psychosocial needs as identified in her comprehensive assessment. 42 C.F.R. § 483.25;

8. By failing to review and revise Mildred Smith's nursing care plan when her needs changed. 42 C.F.R. § 483.20;

9. By failing to notify Mildred Smith's family and physician of a need to alter her treatment significantly 42 C.F.R. §483.10(b)(11);

10. By failing to provide a safe environment. 42 C.F.R § 483.15(h); and

11. By failing to administer Little Rock Healthcare in a manner that enabled it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. 42 C.F.R. § 483.75;

c) By violating Ark. Code Ann. §§ 5-28-101 and 5-28-103 by criminally abusing and **neglecting** Mildred Smith and by failing to report that abuse in violation of Ark. Code Ann. § 5-28-203.

30. A reasonably prudent nursing home, operating under the same or similar conditions, would not have failed to provide the care listed in the above complaint. Each of the foregoing acts of negligence on the part of Defendants was a proximate cause of Mildred Smith's injuries as more specifically as described in Paragraph 10, which were all foreseeable.

31. As a direct and proximate result of such grossly negligent, willful, wanton, reckless, malicious, and/or- intentional conduct, Mildred Smith suffered injuries as described in Paragraph 10, and Plaintiff asserts a claim for judgment for-all compensatory and punitive damages against Defendants including, but not limited to, medical expenses, pain and suffering, mental anguish, disability, humiliation, loss of enjoyment of life, emotional distress and death in an amount to be determined by the jury, and exceeding that required for federal court jurisdiction in diversity of citizenship cases, plus costs and all other relief to which Plaintiff is entitled by law.

COUNT THREE VIOLATIONS OF THE ARKANSAS LONG TERM CARE RESIDENTS RIGHTS STATUTE PURSUANT TO ARK. CODE ANN. §20-10-1201. et seq.

32. Plaintiff incorporates all of the allegations in Paragraphs 1 -31.

33. Defendants had a statutorily mandated responsibility to provide Mildred Smith her nursing home resident's rights as set forth in Ark. Code Ann. § 20-10-1201, *et seq*.

34. Defendants' responsibilities to Mildred Smith as outlined in Ark. Code Ann. § 20-10-1201, *et seq.*, are non-delegable in that Defendants are directly liable for deprivations and infringements by any person or entity under their direct and indirect control, including their employees, agents, consultants, and independent contractors, whether in-house or outside entities, individuals, agencies, or pools, or caused by Defendants' policies, whether written or unwritten, or common practices.

35. The duties alleged in the immediately preceding paragraph include, but are not limited to, proper training and supervision, proper hiring, background and referral checks and proper retraining and dismissing of employees, agents, consultants, and independent contractors.

36. Notwithstanding the responsibility of Defendants to provide her with these statutorily mandated nursing home resident's rights, Mildred Smith was deprived of such rights by Defendants' failure to provide adequate and appropriate health care and protective and support services, including therapeutic and rehabilitative services consistent with her resident care plan. These failures include, but are not limited to, the following:
a) Failing to provide adequate and appropriate health care, protective, and support services, thus leading to the development and worsening of bedsores, malnutrition, anemia, dehydration, an infected PEG tube, a fractured right distal tibia, contractures, a urinary tract infection, urosepsis, - renal insufficiency and death;

b) Failing to provide adequate and appropriate therapeutic and rehabilitative services;

c) Failing to provide adequate and appropriate supervision and protection of Mildred Smith;

d) Failing to develop, implement, and update an adequate and appropriate resident care plan to meet the needs of Mildred Smith;

e) Failing to maintain accurate medical and/or clinical records that contain sufficient information to justify the diagnosis and treatment and to accurately document the results, including, at a minimum, documented evidence of assessments and the needs of the resident, of an establishment of appropriate plans of care and treatment, and of the care and services provided;

f) Failing to appropriately monitor Mildred Smith and recognize significant signs and symptoms of change in her health condition;

g) Failing to properly notify the attending physician of Mildred Smith of significant changes in her physical condition;

h) Failing to properly notify the family of Mildred Smith of significant changes in her health status;

i) Failing to properly supervise staff;

j) Failing to properly train staff; and

k) Failing to treat Mildred Smith courteously, fairly, and with the fullest measure of dignity.

37. As a result of the aforementioned violations, Plaintiff, pursuant to Ark. Code Ann. § 20-10-1209(a)(4), is entitled to recover actual damages in an amount exceeding that required for federal court jurisdiction in diversity of citizenship cases, because the aforementioned violations are the result of Defendants failing to do that which a reasonably careful person would do under circumstances similar to those shown by the evidence in this case, which caused the injuries of Mildred Smith, as more specifically described in this Complaint.

38. The aforementioned violations of the Arkansas Resident's Rights Statute by Defendants were willful, wanton, gross, flagrant, reckless, and conducted with conscious indifference to the rights of Mildred Smith and, pursuant to Ark. Code Ann. § 20-10-1209(c), Plaintiff is entitled to punitive damages.

COUNT FOUR WRONGFUL DEATH

39. Plaintiff incorporates all of the allegations in Paragraphs 1 - 38.

40. As a direct and proximate result of the previously alleged conduct, all of which was grossly negligent, willful and wanton, outrageous, reckless, malicious, and/or intentional, Defendants caused the death of Mildred Smith.

41. Mildred Smith suffered personal injury, including excruciating pain and suffering, mental anguish, emotional distress, humiliation and death, all of which caused her family to suffer more than normal grief upon losing their, loved one.

42. Plaintiff prays for all compensable damages against Defendants for the wrongful death of Mildred Smith, including the grief suffered, as well as the expenses of the funeral and other related costs.

43. As a direct and proximate result of such grossly negligent, willful, wanton, reckless, malicious, and/or intentional conduct, Plaintiff asserts a claim for judgment for all compensatory and punitive damages against Defendants including, but not limited to, medical expenses, pain and suffering, mental anguish, disability, humiliation, loss of enjoyment of life, severe emotional distress and death as well as funeral expenses and related costs against Defendants in an amount to be determined by the jury and exceeding that amount required for federal court jurisdiction in diversity of citizenship cases, plus costs and all other relief to which Plaintiff is entitled by law.

DEMAND FOR JURY TRIAL

44. Plaintiff demands a trial by jury.

PRAYER FOR RELIEF

WHEREFORE, Plaintiff, Mary E. Hughes, as Executrix of the Estate of Mildred Smith, Deceased, and on Behalf of the Wrongful Death Beneficiaries of Mildred Smith, prays for judgment against Defendants as follows:

1. For damages in an amount adequate to compensate Plaintiff for the injuries and damages sustained.

2. For all general and special damages caused by the alleged conduct of Defendants.

3. For the costs of litigating this case.

4. For punitive damages sufficient to punish Defendants for their egregious and malicious misconduct in reckless disregard and conscious indifference to the consequences to Mildred Smith and her statutory beneficiaries and to deter Defendants and others from repeating such atrocities.

5. For all other relief to which Plaintiff is entitled by Arkansas law.

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